CONFIRMATION OF NEW PROVIDER TRAINING

Please complete the following and submit, within 48 hours, to:

CHWP_Provider_Relations@centene.com OR FAX to 855-463-4257

REQUIRED: Initial #1 OR #2

1. _____ (initial) I have received California Health & Wellness' New Provider Training materials, reviewed them for training purposes, and understand essential components of California Health & Wellness' Medi-Cal plan including basic information about public health programs available to California Health & Wellness Medi-Cal members, California Health & Wellness' quality improvement program, interpreter services and provider tools to care for diverse populations.

OR

2. _____ (initial) I have completed California Health & Wellness' new provider training online and understand essential components of California Health & Wellness' Medi-Cal plan including basic information about public health programs available to California Health & Wellness' Medi-Cal members, California Health & Wellness' quality improvement program, interpreter services and provider tools to care for diverse populations.

REQUIRED: Initial #3

3. _____ (initial) In addition, I understand my responsibilities related to California Health & Wellness' Medi-Cal Managed Care services, policies and procedures and ways to communicate between providers, members and California Health & Wellness. I understand how to access and find information on California Health & Wellness' website or Operations Guide on claims and payment policies, CCS conditions and referral process, Case Management services, Medi-Cal benefits and other services available, including tools to care for a diverse population.

_____ _____ _____

Provider Name (PRINT) Provider Signature Date

_____

Provider Address (Street, City, Zip)

_____ _____

Phone Number Email Address

INTERNAL USE ONLY

_____ _____ _____

Received Date Data Entry Date Provider Representative